ORIGINAL ARTICLE

Mental health consumer perspectives of a person-centred multidisciplinary care planning meeting on a rehabilitation inpatient unit

Eliza O'Donohue[1] | Melissa Aguey-Zinsou[1] | Elisa Yule[1] | Ian Fairhurst[2] | Marcie Debaets[2]

[1]Occupational Therapy, School of Allied Health, Faculty of Health Sciences, Australian Catholic University, North Sydney, New South Wales, Australia

[2]South Eastern Sydney Local Health Service, Sydney, New South Wales, Australia

Correspondence
Melissa Aguey-Zinsou, Occupational Therapy, School of Allied Health, Faculty of Health Sciences, Australian Catholic University, Tension Woods House, 8-20 Napier St, North Sydney, NSW 2060, Australia.
Email: melissa.agueyzinsou@acu.edu.au

Abstract
Mental health consumers are seeking genuine involvement in the planning regarding their treatment and care; however for many consumers in inpatient mental health settings, there is not the opportunity to participate. Current research evaluating person-centred multidisciplinary care planning initiatives in inpatient settings from the consumer perspective is limited. The aim of this study was to explore the consumer perspective of a person-centred multidisciplinary care planning meeting implemented in an Australian inpatient mental health rehabilitation unit. This study used a focused ethnographic design with data collection including fieldnotes, observations of meetings and interviews. Ten individuals participated in the study, with two participating in meeting observations and eight participating in structured interviews. Participants were consumers with a mental health diagnosis admitted to a mental health rehabilitation unit for assistance with achieving their goals for community living. Findings were analysed utilizing thematic analysis. Findings showed that consumers' experiences of the care planning meetings were positive. Themes included; 'It's about you', 'Making decisions and expressing opinions', 'Staff involvement in care planning' and 'Supporting consumer recovery'. These findings add the consumer perspective to the existing evidence base and support the implementation of person-centred multidisciplinary care planning meetings in inpatient mental health settings.

KEYWORDS
mental health recovery, mental health services, patient care planning, patient care team, patient participation

INTRODUCTION

Recovery-oriented practices are being implemented by mental health services internationally (Clossey & Rheinheimer, 2014; Kidd et al., 2014; Waldemar et al., 2016), with consumer involvement in care planning recognized as a person-centred and recovery-oriented approach which facilitates consumer recovery (Kidd et al., 2014; Simpson et al., 2017; Tondora et al., 2014). Consumers are seeking to have a defined role within care planning where they can be supported by individual health professionals and organizations (Grundy et al., 2016). Consumers want to have their voice heard and genuinely participate in their care planning (Bee et al., 2015; Millar et al., 2016; Newman et al., 2015). There is a growing body of evidence that indicates collaboration through person-centred care planning may lead to improvements for consumers in health outcomes and self-management of illnesses (Coulter et al., 2015). Benefits of person-centred care planning are described

as 'strengthen empowerment, self-efficacy, developing a positive identity, framing the mental illness, self-managing the mental illness and developing valued social roles,' and gaining a greater understanding of 'what the person desires in his or her life and how the treatment can support the recovery process' (Jørgensen & Rendtorff, 2018, p. 498).

However, within inpatient mental health settings, research exploring collaboration in care planning between consumers and staff is limited (Waldemar et al., 2016). Overall, consumers are dissatisfied with their involvement in care planning (McCann et al., 2008; Simpson et al., 2017) and report the provision of insufficient treatment information and passive or tokenistic involvement (Bee et al., 2015; Millar et al., 2016; Newman et al., 2015; Reid et al., 2018; Simpson et al., 2017). Notably, care planning can be one-on-one care coordination between consumers and care coordinators or be between consumers and the team of people they identify as important to their recovery journey (Tondora et al., 2014). The latter form of care planning is the focus of this study.

BACKGROUND

Within mental health settings, decisions about consumers' care are often made by a multidisciplinary team (Tondora et al., 2014). Therefore, to provide a genuine person-centred approach, it is necessary to facilitate involvement in care planning at the multidisciplinary team level. Research regarding consumer involvement in multidisciplinary person-centred care planning is limited. A systematic review of multidisciplinary team meetings in community mental health settings found that research regarding multidisciplinary team functioning was limited and a clearer understanding of multidisciplinary team functioning is needed (Nic a Bháird et al., 2016). This review found no studies involved consumers as participants in multidisciplinary team meetings, and the effect involvement could have for consumer outcomes has yet to be established (Nic a Bháird et al., 2016).

Studies which did investigate outcomes of person-centred multidisciplinary care planning utilized processes such as a collaborative care team (van der Voort et al., 2015), treatment planning conferences (Jaeger et al., 2015) and a person-centred employment planning team (Gervey et al., 2009). While these processes differed, they were similar in that they outlined a care planning meeting in which the consumer, health professionals and other support people attend, to develop a treatment plan. Furthermore, the initial planning session was used to collaboratively identify consumer goals, with following sessions used to monitor and evaluate progress. These studies found positive effects on symptoms of depression (van der Voort et al., 2015), improvements in functional outcomes (Jaeger et al., 2015) and a 65% success rate in vocational engagement (Gervey et al., 2009).

Two further studies, a protocol (Stanhope et al., 2015) and a progress report (Tondora et al., 2010), refer to care planning as involving the people who are supportive of the consumer's recovery within the planning meeting. However, these studies did not report consumer outcomes or perspectives of person-centred care planning. (Stanhope et al., 2015; Tondora et al., 2010).

Haines et al. (2018) explored a redesigned multidisciplinary team meeting in a forensic service in which consumers were invited to attend. However, consumers were provided limited meaningful engagement as they were only invited to attend the meeting at the end once decisions had been discussed and agreed upon (Haines et al., 2018). While some consumers reported they felt they had some say in decisions, further process and cultural change to encourage genuine and meaningful consumer involvement are required (Haines et al., 2018).

Other processes identified relating to consumer involvement outside of the multidisciplinary team meetings include involving consumers in nursing handover meetings (Olasoji et al., 2020) and individual care planning meetings (Reid et al., 2018). While Reid et al. (2018) focused on a care plan developed between a consumer and a nurse, the intention was for this care plan to be used to guide the consumer's treatment by the wider multidisciplinary team. However, the consumer perspective was that the wider team did not incorporate the care plan into treatment planning and was only of relevance to the interaction between them and the nurse. Reid et al. (2018) recommended that the wider multidisciplinary team needs to be involved (and not just individuals within the team) for collaborative care planning to be useful to consumers.

Limitations in existing research include inadequate intervention description and measurement of consumer involvement. The inadequate intervention description makes it difficult to ascertain the degree to which consumers were involved in their care planning. While the studies provide some description of consumers' involvement, only two articles include measurement tools which assessed the degree to which services are person-centred (Stanhope et al., 2015; Tondora et al., 2010). Furthermore, some of the care planning initiatives existed among a broader intervention programme rather than solely focusing on the care planning intervention (Gervey et al., 2009; Jaeger et al., 2015; van der Voort et al., 2015).

Furthermore, research into consumers' perspectives of person-centred multidisciplinary care planning is limited. It is important to incorporate the unique expertise of consumers throughout service planning, delivery and evaluation to ensure the services they receive are meaningful to their lives (Anthony et al., 2003; Hitch & Lhuede, 2015; Kidd et al., 2014). Therefore, highlighting the necessity of exploring consumers' perspectives across service delivery and research.

In order to address the limitations in the literature and acknowledge the importance of the consumer perspective, this study aimed to evaluate the consumer perspective of a person-centred multidisciplinary care planning meeting (referred to in this article as personal planning and review (PP&R) meetings—see description below). Specifically, this study explored the following questions:

1. What is involved in the process of a person-centred multidisciplinary care planning meeting?
2. What are the experiences of consumers who participate in PP&R meetings?
3. From the consumer perspective, to what extent do PP&R meetings follow the outlined intervention process?

METHODS

Personal planning and review (PP&R) meetings

Staff at an inpatient mental health rehabilitation unit in an Australian metropolitan hospital developed an initiative, called personal planning and review (PP&R)

meetings, to involve consumers in their care planning and to reflect recovery principles. PP&R meetings replaced traditional multidisciplinary team meetings.

PP&R meetings are consumer led care planning meetings. The agenda for the meeting is developed by the consumer and care coordinator prior to the meeting based on a care plan template and the consumer's recovery goals. The wider multidisciplinary team members, family, friends and carers and community services attend the PP&R meeting if invited by the consumer.

PP&R meetings were an established process on the unit for 2 years prior to this study, and all consumers on the unit were offered the opportunity to participate in the process. On the rare occasions when consumers would decline to participate, a modified PP&R process would be used, for example, the process would be delayed for a short period of time until the consumer felt ready to participate, or the consumer would collaborate to develop their goals with their care coordinator who would then speak on their behalf at the meeting.

The template for intervention description and replication checklist (TIDIER) has been used to provide a detailed description of PP&R meetings to assist health professionals who are interested in implementing PP&R meetings (Hoffmann et al., 2014), see Table 1.

TABLE 1 Description of the personal planning & review meetings using the template for intervention description and replication (TIDieR) (Hoffmann et al., 2014).

Name	Personal planning and review (PP&R) meetings: Consumer-led multidisciplinary care planning meetings in an inpatient mental health rehabilitation unit
Why	To give consumers a seat at the decision-making table to lead their care planning meetings
What (materials)	• Notification board; date, name of consumer, people attending • Meeting room • Agenda/care plan template (agenda developed by consumer and care coordinator prior to the meeting based on care plan template and consumers' recovery goals) • Personal planning & review format
What (procedure)	• Personal planning & review format: A brief guide to the consumer review meetings highlighting the timing and frequency, and procedure prior to meeting, during the meeting and after the meeting (available from authors on request)
Who	• Consumer: Adult mental health consumer who is currently an inpatient within the mental health rehabilitation unit • Care Coordinator: Identified key worker, who works to support the consumer prior, during and after the PP&R meeting • Treating team (psychiatrist, psychologist, occupational therapist, social worker, peer worker): Invited by the consumer or their care coordinator to participate in PP&R meeting • Family, carer or friends: Invited by the consumer or their care coordinator to participate in PP&R meeting • Community services (community mental health team, support worker from community managed organization): Invited by the consumer or their care coordinator to participate in PP&R meeting
How	• Mode of delivery: Face to face; group
Where	Inpatient mental health unit; meeting room (relevant features: consumer identifies preferred location, room should promote all people being involved in the meeting)
When and how much	Approx. 30 min in duration. First meeting 1 week following admission, then every 3–4 weeks for the duration of the inpatient admission. Meetings to be booked 2–3 weeks in advance
Tailoring	The meeting is planned to meet the needs of consumers, so all reasonable adaptations to personalize the meeting should be attempted.
How well	Intervention adherence monitored by the nurse unit manager. Following the meeting, the consumers' care coordinators provide them with a copy of the minutes and ask them about their experiences of the meeting.

Study design

A focused ethnographic research design was implemented, to describe and interpret the consumers' experiences of PP&R meetings as an aspect of the unit's recovery culture (Spradley, 1979). This study used fieldnotes, observations of PP&R meetings and semi-structured interviews with consumers to collect data. A focused ethnography aims to interpret and attribute meaning to a selected aspect of a culture within a specific community or organization (Muecke, 1994; Spradley, 1979). This design is common in health science research where health professionals seek to substantiate practice and improve cultural appropriateness of services (Muecke, 1994). Approval for this study was gained from the Human Research Ethics Committee of the South Eastern Sydney Local Health District and the COREQ checklist has been used when reporting this study (Tong et al., 2007).

Setting

The study was undertaken in a 12-bed mental health rehabilitation inpatient unit in Australia. The unit is ward of a general hospital staffed with nurses, allied health professionals, a peer worker and a psychiatrist and provides mental health rehabilitation services to adults with mental health conditions, based on biopsychosocial and recovery principles. Consumers are primarily admitted to the unit from the community mental health service; however, referrals can also come from the acute inpatient unit of the hospital. Consumers are treated on both a voluntary and involuntary basis under the NSW Mental Health Act 2007. Each consumer at the unit has a care coordinator appointed from the inpatient staffing team and the unit runs a weekly group programme.

Participants

Interviews: Interviews were only conducted with consumers. The inclusion criteria for the interviews were adults with a mental illness, who were residing at the inpatient unit on a voluntary basis, with previous experience of PP&R meetings. The exclusion criteria were consumers who had been admitted to the unit in accordance with the NSW Mental Health Act 2007. The NSW Mental Health Act 2007 is legislation that covers the assessment, treatment and rights of people with a mental health disorder. Consumers were also excluded from participating if they were unable to provide informed consent or had no previous experience of PP&R meetings. Consumers were excluded if they had already participated in the study through an observation of their PP&R meeting as there were concerns that this would lead to the participant's perception that the researcher was a member of the treating team, in turn potentially affecting the depth and quality of data gathered.

Observations of PP&R meeting: The inclusion and exclusion criteria for consumers for the observations was the same as for interviews, except that consumers who had already participated in an interview were not eligible for observation. People other than the consumer, present during the observation of the PP&R meetings, also participated in the study. This included clinicians, family and friends and other supports. There were no inclusion or exclusion criteria for clinicians, family, friends and other supports beyond being invited to the PP&R meeting by the consumer.

Recruitment and consent

Consumers admitted to the unit were screened for eligibility against the inclusion/exclusion criteria by the fourth and fifth authors, who were known to the consumers. Once a consumer was identified as eligible, the first author was introduced to the consumer by the fourth or fifth author or another available staff member. The first author was unknown to the consumers or health professionals at the unit, to reduce any bias and ensure consumers felt open to discussing their experiences. The first author discussed the purpose of the research, provided the consumer with the participant information sheet and consent form and received written consent. From here, a time was scheduled for either the observation of their PP&R meeting or an interview. For the observations of PP&R meetings, written consent was sought from everyone who was present at the commencement of the PP&R meeting.

Data collection

This study used fieldnotes, observations of PP&R meetings and interviews. All data were gathered by the first author. Fieldnotes were kept as a written record of general observations throughout the research process (Emerson et al., 1995).

Observations of PP&R meetings were conducted to document the process with impartial awareness which is difficult to attain solely from interviews. To enhance the objectivity of the observations, the researcher documented descriptive fieldnotes with a note-taking guide. The note-taking guide listed all of the recommended steps of the PP&R meeting process, for example, asking the consumer if they had time to meet with the care coordinator to prepare for the meeting, and checking whether the strengths assessment was used in the meeting.

The interviews were both structured (28 statements) and semistructured. For the interviews, a written questionnaire, consisting of 24 statements, was administered verbally by the researcher. The questionnaire was

designed by the mental health rehabilitation team including a peer worker. The researcher asked the consumer the 24 statements, and the consumer rated their response from strongly agree to strongly disagree using a five-point visual analogue scale (VAS). For each statement, the researcher asked follow-up questions, such as 'what made you choose that response?', 'can you provide me with any examples of why you have chosen that response?' to explore the consumer's response. After the questionnaire was administered, the researcher concluded the interview by asking a further three open-ended questions about what participants liked and disliked about PP&R meetings and whether the PP&R meeting supported their recovery (see Figure 1). One interview was conducted with each participant, with only the researcher and participant present. Interviews were approximately 30–45 min and were completed on the unit in a private and quiet space of the consumers' choice, for example, in a sitting room or outside courtyard. Responses were recorded through fieldnotes, a common method of recording in ethnography (Emerson et al., 1995).

Data analysis

Data analysis for the structured VAS included descriptive totals/frequencies. Braun and Clarke's thematic analysis was utilized to identify key themes across interviews (including data from the follow-up questions for the 24 questionnaire statements and the three open-ended questions at the conclusion of the questionnaire) and fieldnotes (Braun & Clarke, 2006). The thematic analysis was primarily completed by the first author with coding and themes reviewed by the second and third authors. To ensure consistency across the ethnographic research design and qualitative analysis, a constructivism epistemology informed the analysis. Constructivism recognizes that knowledge is constructed based on perception and experience (Braun & Clarke, 2006).

The 24 questionnaire statements were separated for analysis into 'consumer experience' statements and 'PP&R process' statements (see Table 2). The three open-ended questions at the conclusion of the questionnaire were analysed together with the consumer experience statements. The data were then coded manually, ensuring the context was not lost. The codes were reviewed to identify themes. These steps were then repeated for the fieldnote data. A coding tree was developed using an Excel spreadsheet to display the data. Themes were reviewed to analyse their relationships and whether they were representative of the data. Following triangulation of themes from interviews and fieldnotes, two further interviews were completed. As no new themes were identified, this suggested data
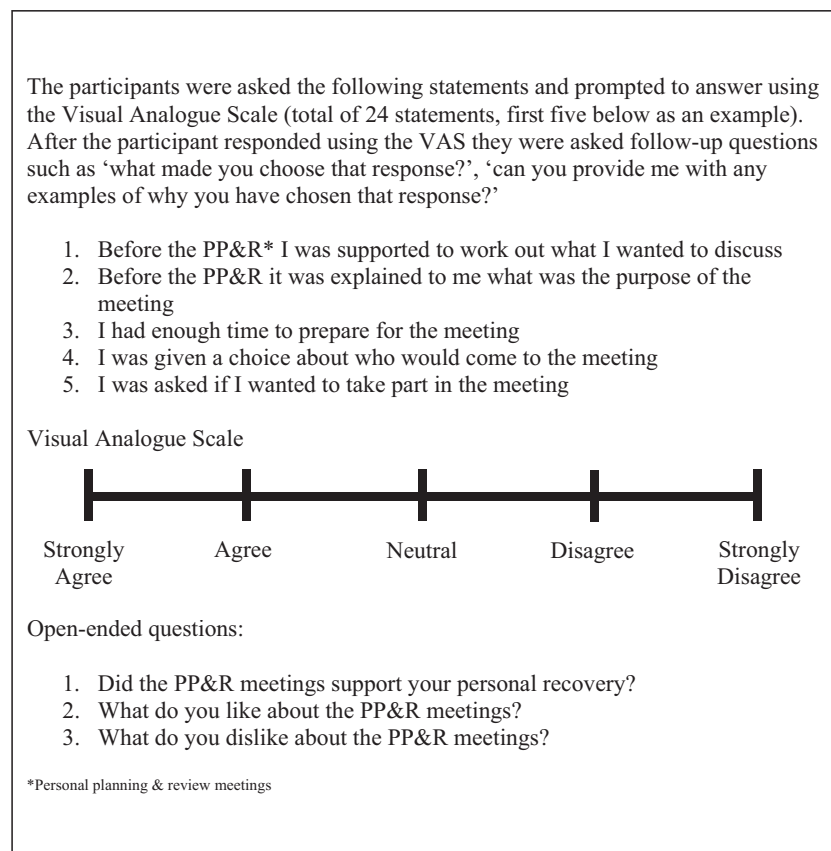
The participants were asked the following statements and prompted to answer using the Visual Analogue Scale (total of 24 statements, first five below as an example). After the participant responded using the VAS they were asked follow-up questions such as 'what made you choose that response?', 'can you provide me with any examples of why you have chosen that response?'

1. Before the PP&R* I was supported to work out what I wanted to discuss
2. Before the PP&R it was explained to me what was the purpose of the meeting
3. I had enough time to prepare for the meeting
4. I was given a choice about who would come to the meeting
5. I was asked if I wanted to take part in the meeting

Visual Analogue Scale

| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

Open-ended questions:

1. Did the PP&R meetings support your personal recovery?
2. What do you like about the PP&R meetings?
3. What do you dislike about the PP&R meetings?

*Personal planning & review meetings

FIGURE 1 Sample of interview questions.

TABLE 2 Frequency of consumer responses to questions from visual analogue scale.

	SA *n*	A *n*	N *n*	D *n*	SD *n*	Total *n*
Consumer experience statements						
Opinions taken seriously by staff	4	4	0	0	0	8
People were positive and encouraging in the way they spoke	4	2	2	0	0	8
Felt safe and listened to	4	3	1	0	0	8
Support to fulfil recovery goals	3	5	0	0	0	8
Room was comfortable and private	3	4	1	0	0	8
Staff respecting my decisions and choices	3	4	1	0	0	8
Equal partner	3	3	0	1	0	7[a]
Meeting went at a good pace	3	4	1	0	0	8
Comfortable expressing opinion	2	5	1	0	0	8
Satisfied with the answers and explanations	2	3	3	0	0	8
PP&R process statements						
Given copy of notes of meeting	4	3	1	0	0	8
Support to work out what I wanted to discuss	4	3	1	0	0	8
Care plan discussed in meeting	4	1	3	0	0	8
Staff writing notes on my behalf	3	2	1	2	0	8
Information written on yellow sheet near office	4	1	3	0	0	8
Knew everyone at the meeting and comfortable with the people there	3	4	1	0	0	8
Meetings happened when they were supposed to	3	2	3	0	0	8
Enough time to prepare for meeting	3	2	2	1	0	8
Explanation of purpose of meeting	3	4	1	0	0	8
Regular meetings	2	5	0	0	0	7[a]
Strengths assessment was used in the meeting	2	3	3	0	0	8
Asked to take part in meeting	1	3	3	1	0	8
Given choice on who attends meeting	1	4	2	1	0	8

TABLE 2 (Continued)

	SA *n*	A *n*	N *n*	D *n*	SD *n*	Total *n*
Staff members spoke with me about my experience	0	1	2	3	0	6[a]

Abbreviations: A, agree; D, disagree; N, neutral; *n*, number of participants; SA, strongly agree; SD, strongly disagree.
aMissing consumer responses.

saturation (Miles & Huberman, 1994). Participants were offered the opportunity to provide their contact details to review the findings; however, no participants provided their contact details. The reporting of this study is presented according to the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al., 2007).

RESULTS

Participants

Overall 10 consumers participated in this study, six males and four females. Two consumers participated in the PP&R meeting observations. Nine consumers participated in interviews, with one consumer withdrawing from the study. Their interview was not conducted as the participant did not want to discuss the research topic after the interview began. Therefore, eight interview responses were included in the data. While demographic data were not collected from participants to protect confidentiality; the recruited sample was representative of consumers on the unit at the time; adults within an age range of 18–65, a primary diagnosis of mostly psychotic disorders of schizophrenia or schizoaffective disorder and an average length of stay of 4–5 months.

Responses to VAS scale

The frequency of participants' responses to questions from the VAS is represented in Table 2. For 22 of 24 questions, the medians were either 4 or 4.5. A median of 4 indicates 'Agree' and a median of 4.5 indicates a score between 'Agree' and 'Strongly Agree. Therefore, the responses for these 22 questions were positive, suggesting positive consumer experience and that the process is being followed accurately. However, there were two exceptions. The median for the question 'I was asked if I wanted to take part in the meeting' was 3.5 (min–max = 2–5); therefore, the score for this question was between 'Neutral' and 'Agree'. The median for the question 'After the meeting, staff members met with me to talk about my experience' was 2.5 (min–max = 2–4), indicating a score between 'Disagree' and 'Neutral'.

Themes of consumer experience of PP&R Meetings

The following themes reflect the consumers' experiences of the PP&R meetings. Names of the participants have been replaced with pseudonyms to protect privacy and confidentiality.

It's about you

Some consumers felt they were the focus of the PP&R meetings. Three consumers expressed that the meetings were about them and claimed ownership of the meeting. Emma stated, 'It's the first time it's about you. It's about you, not them'. One way that consumers felt they were the focus of the meetings was through staff listening to them. Mitchell noted that during his meeting, 'there were no interruptions or abrupt second opinions'. Furthermore, John highlighted the effect of being central to the meeting, stating it 'shows that I'm important'.

Making decisions and expressing opinions

Participants highlighted that during PP&R meetings, they had the opportunity to be involved in their care planning through making decisions and expressing their opinions. In his interview, David expressed that he was 'leading the PP&R'. In one of the observations, the participant's care coordinator sat next to the participant and held the plan between them, creating the feeling that they were a team, chairing the meeting.

Participants indicated that during PP&R meetings, they could make their own decisions and talk about their opinions and preferences. John stated, 'you can make your own decisions' and 'we would tell them what we wanted'. This was further supported in the observations where participants were observed discussing what was needed to achieve their goals.

In PP&R meetings, staff also prompted participant involvement through seeking their preferences or opinions. Isobelle noted, they were 'asking me what direction I wanted to go and what I wanted to do'. Staff were observed prompting consumers to discuss topics such as 'the first goal was [consumer goal], would you like to discuss this?'

In contrast, one consumer stated that they did not feel like 'an equal partner with doctors and nurses. They have more control, they can keep me longer' (Michael).

Staff involvement in care planning

As indicated in interviews and observations, staff were involved in the PP&R meetings in numerous ways. Some consumers spoke more generally, noting staff provided 'lots of support' (David) and they received 'positive support from each of them' (Isobelle). In one of the interviews, and both observations, staff highlighted the consumers' strengths.

Consumers felt that staff accepted their decisions. John explained 'you can make your own decisions and they'll let you do that'. Consumers also felt staff supported goal attainment through working collaboratively with them to achieve goals. David highlighted this, stating, 'this is what I want and then we talked about how to go about it'. This was observed within the PP&R meetings when staff took responsibility for actions consumers had identified.

Consumers reported staff were also involved in the meetings through giving suggestions. For some consumers, like Mitchell, these suggestions were well received; 'I can deal with second opinions if they are delivered tactfully'. However, not all consumers felt the same, as they were 'uncomfortable with that opinion' (David), or 'didn't quite understand the things they told me' (Louisa).

Supported consumer recovery

When asked whether they thought the PP&R meetings supported recovery, six of the eight consumers responded positively. Three consumers highlighted ways the meetings supported recovery. David responded 'yes [people were] following up what I wanted in PP&R', while John noted that it's a 'good time to build your future', and Emma stated '[It's] part of recovery, one day I won't need PP&R'. In contrast, two consumers were more reserved in their judgement about whether the meetings supported recovery, with Michael stating 'yeah, we'll see when I leave' and Jack remarking 'hopefully, I hope it did'.

Consumer experience of the process of PP&R meeting

As part of the interview, consumers were asked about their experiences of the meeting process. The following consumer responses have been gathered below in relation to the elements of the process. It is important to note that sometimes the responses given verbally by the participants varied from the responses indicated on the VAS.

Informing consumers about their PP&R

Most consumers (7/8) commented that the meetings were explained to them. Emma stated 'They explained it's a part of the therapy, the program… Part of getting better.

It changes with your needs. Its more about your goals' and Isobelle noted that 'There are three pieces of A4 paper on the (bedroom) wall about the PP&R meetings – talks about what they are and role of client in meeting'. Most consumers (6/8) felt that they were given notification of the meeting through a laminated yellow piece of paper which was observed by the researcher on a wall in a central location of the unit.

Choice in participating

Half of the participants felt that they were asked to attend whereas the other half felt that they had to attend, evidenced by Emma's statement, 'PP&R is not an option, part of the program'.

Preparing for the meeting

Three participants spoke about engaging in preparation activities for the meeting. David stated that 'If I wasn't busy I would sit down and talk about what I wanted to discuss'. Half of the participants felt that they had enough time while two noted that they did not have enough time to prepare.

Timing of the meetings

Majority of participants (5/8) reported the meetings occurred at their established frequency (3–4 weeks) and felt that they happened as scheduled. There was variation in responses regarding the experience of the pace of the meeting; three participants stated it was a 'good pace', two stated 'too quickly' and one stated 'too long'.

People attending

Michael response is reflective of most participants' experiences (6/8 participants), stating that 'Yes I was given a choice. Care coordinator asked me who I would like to come'. Whereas the two remaining participants did not feel like they had a choice with Louise stating that she 'didn't know who was coming in'. Reports varied about the number of people attending meetings, with participants expressing that there was 'two to five people'. In the meetings that were observed, there were six people in the meetings. The people attending the meeting, as reported from participant interviews and the observations included; psychiatrists, psychologists, social workers, nurses, community case workers and family. Two participants reported that they 'felt intimated by all the people' (Louisa), whereas four participants expressed that it facilitated coordination between staff, 'Everyone else

could hear what I was saying and knows where you're up to' (David).

Care plan brought into meeting

Four participants reported that their care plans were brought into the meetings, while two stated they were not. In both observations of the meeting, staff brought the care plan into the meeting. In one meeting, the care plans were distributed to all individuals attending; participant and staff. In this meeting, the care plan was used to structure the meeting.

After the meeting

There are three actions which are to occur after the meeting; consumers being asked their experience, notes being written with consumer and consumers receiving a copy of notes from the meeting. The majority of participants (6/8) reported that after their meetings, they were not asked about their experience. John stated 'They just went to the next meeting without saying anything'. One participant reported that she was asked about the meeting. Four participants reported that they were asked for their input when staff were documenting the notes from the meetings, while two stated they were not. Six of the participants reported that they were given a copy of the notes from the meeting, David stated he was given a 'Brief summary of what we talked about'. Two participants reported that they did not receive a copy and Mitchell stated 'I didn't know that was supposed to be a thing'.

DISCUSSION

PP&R meetings aim to genuinely involve consumers within their care planning and facilitate consumer recovery. This study identified that consumers' experiences of PP&R meetings were positive and that the majority of the PP&R intervention process was being followed. These findings are important as they add the consumer perspective to the limited evidence base regarding person-centred multidisciplinary care planning and provide support for its implementation in inpatient mental health settings where its implementation is limited (Waldemar et al., 2016). This study's findings differ from existing research (Gervey et al., 2009; Jaeger et al., 2015; Stanhope et al., 2015; Tondora et al., 2010; van der Voort et al., 2015) in that the previous studies focused on the outcomes of the broader interventions they were a part of (i.e. acquiring employment, functional outcomes, mental health symptoms), whereas the current study explored the experience of engagement in care planning.

The literature consistently emphasizes the importance of genuine consumer involvement within care planning to support recovery (Bee et al., 2015; Millar et al., 2016; Newman et al., 2015; Reid et al., 2018). The theme of 'It's about you' offers evidence to suggest that consumers who experienced the PP&R meetings felt they were genuinely involved through feeling like the focus of the meeting and feeling as though they were important. Additionally, most consumers agreed that PP&R meetings supported their recovery. The study's findings were compared to CHIME, a conceptual framework of recovery developed from a synthesis of consumer perspective studies (Leamy et al., 2011). Its acronym, CHIME, represents five processes of recovery: Connectedness, hope and optimism about the future, identity, meaning in life and empowerment (Leamy et al., 2011). Table 3 highlights the ways PP&R meetings may support some processes of recovery and how PP&R could be improved to further support recovery.

Consumers identified that staff involvement had an influential role in their experience of the meetings. Consumers felt that staff provided support, highlighted strengths, listened to them, accepted their decisions and supported goal attainment through suggesting strategies to achieve goals. These were important criteria to address that consumers have been requesting in the existing evidence base (Grundy et al., 2016). However, not all participants in this research reported that staff suggestions were made well, with some consumers identifying that it was important for staff suggestions to be 'tactful' and to consider how they may be interpreted as some consumers felt uncomfortable with the opinions or did not understand them. Satisfaction with explanations was the lowest rated aspect of consumer experience on the VAS and regarding the PP&R meeting process, staff providing an opportunity for consumers to discuss their experience after the meeting was the lowest rated. Seeking feedback from consumers after the meeting may indicate a possible helpful strategy for the consumer to be able to address and seek support in case of any negative experiences and also an opportunity for staff to be able to give feedback to the team to enable them to learn how to provide better responses and explanations to consumers in future. Other strategies for staff to support consumer engagement in care planning processes, as suggested by consumers in previous literature, include developing a collaborative therapeutic relationship; supporting active consumer engagement giving consideration to their current capacity and confidence with care planning; ensuring care plans are holistic, descriptive, relevant and translate into tangible outcomes; and providing education regarding meaningful treatment options and their legal rights including their right to be involved in their care planning meetings (Grundy et al., 2016).

In this study, consumers reported that PP&R did allow them to take a lead in making decisions. There is growing research into an emerging practice of shared decision-making (SDM) (Tondora et al., 2014). SDM is 'a process in which clinicians and patients work together to select tests, treatments, management or support packages, based on clinical evidence and the patient's informed preferences; it involves the provision of evidence-based information about options, outcomes and uncertainties, together with decision support counselling and a system for recording and implementing patients' informed preferences' (Coulter & Collins, 2011, vii). Research has shown that SDM interventions, such as groups led by nurses and peer workers, may enhance the quality of SDM in wider team meetings (Paudel et al., 2018). It has been highlighted in previous literature that for

TABLE 3 Conceptual framework of recovery processes with related findings from current study.

CHIME[a] recovery framework	Related findings from the current study	
	Processes of PP&R meetings supporting recovery	Improvements to PP&R meetings to further support recovery
Connectedness	Staff supporting consumers in PP&R meetings	Staff may further support consumers by reflecting with them about their experience of the PP&R meetings
Hope and optimism about the future	Positive attitudes of staff and the consumers' belief in the possibility of recovery	Nil
Identity	Nil	Nil
Meaning in life	PP&R meetings provide opportunities for consumers to discuss and work towards engaging in meaningful life and social goals	Nil
Empowerment	During PP&R meetings as consumers are given the opportunity to take personal responsibility and control over their life through leading the meetings, making decisions and expressing their opinions	• Choice in attending the meeting and others who attend meeting, would provide further control • Reflecting with consumers about their experience of the PP&R meetings may provide the opportunity to reflect on ways to further engage within the meetings

[a]CHIME, connectedness, hope and optimism about the future, identity, meaning in life, empowerment (Leamy et al., 2011).

collaboration to be effective, it should be not only with individual members of the team but also with the wider team (Reid et al., 2018). Therefore, where relevant, for example in inpatient settings, further research into SDM may benefit from adopting PP&R processes for wider team meetings so that collaborative care planning can be both with individual staff but also the wider team (Reid et al., 2018).

This study varies from the existing literature in that it measured the involvement of consumers in their meeting, provides a detailed explanation of the PP&R meeting process and the extent to which the meeting intervention process was followed. While the VAS scale indicates that the majority of the process was being followed, variation in consumers' experience of the meeting process highlights the importance of needing a person-centred process which is inherently adaptable and individualized to the needs of each consumer. The elements of the process where further consideration to individualized needs should be given include choice in participating in the meeting, preparation for meetings, pace of the meeting, choice in who attends the meeting, asking about their experience of the meeting, bringing the care plan into the meeting, writing notes with the consumers and giving a copy of the notes to the consumer. For example, consumers may want more time to prepare for meetings or for their meetings to be shorter or longer. The creation of a supportive environment and therapeutic relationship and regular reflection with consumers about their experience of the PP&R meetings is key in being able to ensure that the meetings are addressing their needs.

Further exploration of PP&R meetings from the staff perspective may also provide further insight into the care planning process including details about barriers and facilitators to implementation. Within the literature, barriers to consumer involvement include limited time to engage with consumers due to understaffing, crowded wards and unpredictable situations (Waldemar et al., 2016); focus on risk management (Haines et al., 2018); lack of clarity about what the expectation or extent of consumer involvement is (Jørgensen & Rendtorff, 2018); staff motivation/ skill level, staff confidence in being able to facilitate a space where consumers feel safe and confident to share their individual circumstances; and difficulty actively involving consumers whether this is due to not having the skills or whether it is related to severity of mental health symptoms (Jørgensen & Rendtorff, 2018; Simpson et al., 2017). The previous study by Reid et al. (2018) emphasized that it is difficult for nurses to change the practice of the wider team to be more person centred and collaborative. PP&R may provide an intervention for the wider team to change practices to be more collaborative and a way to address previously identified barriers, for example through setting expectations for the process, consumers and staff receiving support to facilitate a person-centred planning meeting and consumers being provided a safe space in

their team meeting through, for example, setting their agenda and inviting who they want present.

Limitations

This study had some limitations. Not recording the interviews may have reduced the credibility of the qualitative findings. Additionally, this meant that transcripts were not recorded and therefore could not be returned for comment. However, the researcher aimed to counteract this by recording consumers' responses verbatim and utilizing negative case analysis to report contrasting views of themes (Miles & Huberman, 1994).

No further demographic information was collected from the participants to ensure their privacy and confidentiality. The research team felt that there would be a higher chance of identification if demographic data were to be included as the inpatient unit is a 12-bed unit with consumer length of stay between 3 and 6 months. Due to time restrictions, the research team were unable to extend the period of data gathering to increase the participants involved.

Recommendations for future research

This is the first known study to explore consumers' perspectives regarding involvement in person-centred multidisciplinary care planning meetings on an inpatient team. Future research should continue to investigate and evaluate consumer involvement in multidisciplinary care planning meetings, such as PP&R meetings, to confirm these findings. This is particularly important given the findings from this study showed that what participants reported on the VAS scale was at times different from their responses during the interview. This may involve exploring the consumer and staff perspective regarding the recovery-oriented nature of the person-centred multidisciplinary care planning meetings on inpatient settings, or the challenges and facilitators to its implementation.

CONCLUSION

This study explored the experiences of person-centred multidisciplinary care planning meetings in an inpatient setting from the consumer perspective. The positive findings suggest staff effectively engaged consumers in their meetings. Strategies such as inviting consumers to participate, collaboratively making decisions, respecting consumer decisions, encouraging consumers to lead discussions and seeking feedback from consumers after collaborative care planning may be useful for other services who are aiming to involve consumers in care planning. This study presents a team-based person-centred care planning initiative which may assist health professionals

when advocating for consumer involvement in order to meet policy standards and improve outcomes for consumers. Future research into staff perspectives or consumer outcomes of multidisciplinary care planning meetings in an inpatient setting is warranted to continue to explore the efficacy of the process and its strategies. More opportunities for consumers to share their perspectives and also exploring co-design in the care planning process is recommended.

Relevance for clinical practice

This study presents and discusses consumer involvement in multidisciplinary meetings from the consumer perspective. This involvement can support consumers to feel as though they are the focus of their care, they are able to make decisions and that they are supported on their recovery journey. Key strategies which supported this included inviting consumers to participate, collaboratively making decisions, respecting consumer decisions, encouraging consumers to lead discussions, focusing on consumer strengths, asking consumers about their experience of the meeting and collaborating with consumers to prepare joint notes from the meeting.

AUTHOR CONTRIBUTIONS
EO led the drafting of the manuscript, data acquisition and analysis, and made substantial contribution to interpretation of data and revising of the manuscript. MA and EY made substantial contributions to conception of the work and the acquisition, analysis and interpretation of the data; and to drafting and revising the work. MD and IF made substantial contribution to the conception and design of the work and the data acquisition. All authors have approved the final version to be published and are accountable for all aspects of the work.

CONFLICT OF INTEREST STATEMENT
This research received no financial support. The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT
The data are not publicly available due to ethical restrictions.

ETHICAL STATEMENT
Ethics approval was granted from the South Eastern Sydney Local Health District Ethics Committee.

ORCID
Eliza O'Donohue https://orcid.org/0000-0002-6283-505X
Melissa Aguey-Zinsou https://orcid.org/0000-0002-8599-0415
Elisa Yule https://orcid.org/0000-0003-3238-3133

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